OGL 2501B v6
Created on: 01/04/12
Revised on: 03/19/15

Physician Certification Statement - Request for Transportation

This form will provide LogistiCare or other authorized transportation provider with information on the appropriate level of transportation needed.

Patient's Name: _____

Patient's ID Number / CIN#:_____ Patient's D.O.B.:_____/_____/_____

Non Emergency Medical Transportation (NEMT)

NEMT includes ambulance, wheelchair and gurney vans, and is provided when medically necessary and you are not ambulatory. The NEMT transportation under Medi-Cal is covered only when your medical and physical condition does not allow you to travel by bus, passenger car, taxicab, or another form of public or private conveyance.

Non Medical Transportation (NMT)

NMT includes transportation for medical appointments and may be provided via taxi, sedans, paratransit such as Access, or fix route transportation such as buses.

Select the type of transportation patient requires:

☐ NEMT ☐ NMT ☐ Transportation is not medically necessary

If you select NEMT, please tell us what **is preventing** the patient from taking non-medical transportation. Failure to complete this section will cause the PCS to be sent back to you for completion: _____

_____

_____

Will the patient use one of the following during the transport? ☐ Wheelchair ☐ Walker ☐ Cane ☐ Other (describe)

_____

Based on the above, what type of transportation does the member require?

NMT: ☐ Sedan/Taxi ☐ Wheelchair

NEMT: ☐ Wheelchair ☐ Gurney/Stretcher ☐ Ambulance

CERTIFICATION

The physician, dentist or podiatrist responsible for providing care for the member is responsible for determining medical necessity for transportation. This Certificate can be completed and signed by an MD, LVN, RN, PA, NP or discharge planner who is employed or supervised by the hospital, facility or physician's office where the patient is being treated and who has knowledge of the patient's condition at the time of completion of this Certificate .

Duration (based on continued health plan eligibility):

☐ **30 days** ☐ **60 days** ☐ **90 days** ☐ **120 days**

Staff/Physician's Name (print): _____

Staff/Physician's Signature: **X**_____Title_____

Date:_____ Contact phone no.: (_____) _____-_____

Please return form by facsimile to LogistiCare, Attn: Utilization Review (877) 457-3352